

## Can Any Good Come From AIDS?

THE FULL IMPACT of the acquired immunodeficiency syndrome (AIDS) epidemic has yet to be felt, even among those most at risk. The disease is lethal, it is clearly spreading, and medical science has not yet found a scientific way to prevent or cure it. There already is significant impact. Where the prevalence is high, there is evidence of serious strain on both the health care system and on traditional cultural mores. It is all too clear that these stresses are likely to bring about unprecedented changes in health care and in society that now can only be imagined. Human behavior and the methods of spread of the disease being what they are, these changes will be local, national, and even worldwide. If the epidemiologic predictions are anything like borne out, human suffering, mortality, and just plain costs will be staggering.

Can some good possibly come from this AIDS epidemic? It seems that some already has. For example, basic biomedical research is receiving more support in the hope that it might lead to better prevention and cure. The Food and Drug Administration has been persuaded to speed up its drug approval process to enable AIDS victims to take a chance on possible amelioration or cure with experimental drugs, with full realization that the safety and efficacy of such drugs might not yet be established. This was something long overdue, even before the AIDS epidemic.

As the AIDS pandemic spreads, there certainly will be other consequences. A new openness and objectivity about sexual practices is already evident. There is new attention being paid to the scourge of drug abuse and its possible role in spreading the disease. New efforts to control sexually transmitted diseases are riding on the coattails of the AIDS epidemic. And if significant changes in sexual practices come about because of the fear of AIDS, a welcome by-product could be some significant reduction in the number of unwanted pregnancies, particularly among teenagers and perhaps even among drug abusers. In some communities there are already measurable trends toward safer sexual practices among gay men.

A rising caseload of patients will place serious stress on the health care system. One can safely predict that when some critical point is reached, the health care resources, monetary and other, will fall significantly short of what is needed, with serious social, economic, and political consequences, first in the community, and then, as things get worse, in the nation and perhaps even in the world. Could any good possibly come of this? In this nation, at least, the health care system already falls short of what is needed, even without the AIDS epidemic, if one considers that 30 or 40 million people have no health insurance at all, and, therefore, have limited access to the system. Nor can our system be considered economically efficient or friction-free. Quite the opposite. Its performance is severely hampered by flawed economic theories and bumbling interventions by government. It is now fettered, restrained and held down by high administrative overhead costs, excessive regulation, costly litigiousness, and well-intended but often ill-informed intrusions into medical practice from government and the private sector. More recently, the health care system is being leached to provide profits for private investors, diverting funds from needed patient care. It will take an enormously powerful

force to shake all this unwanted baggage loose and make more streamlined health care available to the growing numbers who need it. Will AIDS prove to be this force, a force strong enough to cut through and reduce the wasteful impediments that in many ways tie the hands of the health care system?

There is yet another dimension. We all live in one world and people move about in it sharing cultures and lifestyles—and spreading AIDS. As AIDS spreads, some commonalities among humans the world over will become more evident. Already, it has been recognized that control of this disease will have to be a worldwide effort, and remarkably quickly, a vigorous worldwide Special Programme on AIDS has been established by the World Health Organization in Geneva. It is quite possible that the AIDS epidemic will open new channels for international understanding and cooperation that could later address other worldwide risk factors affecting human health and well being.

One can only conclude that at least some good can come from the AIDS epidemic, terrible and terrifying as it surely is.

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## Ruling Out Myocardial Infarction—Updating a Good Idea

WHEN CORONARY CARE UNITS were first devised, the goal was to provide an isolated area of the hospital where patients with definite acute myocardial infarctions could have ready access to the newly developed techniques of continuous electrocardiographic monitoring and direct current defibrillation.<sup>1</sup> Testimony to their initial success was in the form of case reports of patients who were successfully resuscitated from what previously would have been fatal ventricular fibrillation.

Within several years, coronary care units assumed an additional purpose: to prevent ventricular fibrillation with the intravenous administration of medications.<sup>2</sup> Once again, the influential literature was principally in the form of uncontrolled observations.

Both the concept of treating ventricular fibrillation and that of preventing it were initially applied to patients who were admitted with clear-cut signs of acute myocardial infarction. The concept that intensive coronary care might be beneficial, even if not truly cost-effective, for patients in whom there was only a suspicion of acute myocardial infarction was never subjected to even a basic level of inquiry. Nevertheless, by the early 1970s, many coronary care units reported that only about 50% of patients had acute myocardial infarctions, and, subsequently, as documented by Murata elsewhere in this issue, this level has fallen to about 30%.

Coincident with this phenomenon, a new term was coined: rule out myocardial infarction (ROMI). The ROMI patient has a clinical history or an electrocardiogram result that warrants a finite suspicion of acute myocardial infarction; further testing is required to establish or exclude the diagnosis. Because such patients also have a finite probability of acute life-threatening complications, such as ventricular fibrillation, if they are having myocardial infarctions, the coronary care unit, which was initially intended to provide